Usual—Customary—Reasonable

A California Perspective

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AMERICAN PHYSICIANS AND American health care insurance agencies have given wide and enthusiastic acceptance to the idea of a uniformity of fee charges for each defined physician's service for all patients of any individual doctor, and to the idea of a range of such usual fee charges, which reflect those of each community, and which can be used to define the amount to be paid by any insuring agency. These ideas have come to be known as the usual, customary and reasonable basis of paying for physicians' services.

As so often occurs, a brief retrospective review of the origin and background of these terms may be very helpful in clear understanding of their usefulness and significance in contemporary society.

Beginning at least as early as 1945, the California Medical Association has been privileged to receive a series of penetrating studies of problems of medical care insurance. Many of these related to problems that were developing in California Physicians' Service (Blue Shield), and reflected some disharmony between the California Physicians' Service in its developing years and a number of practicing physicians in California.

A fairly direct development sequence in such studies began with a psychological study of the doctor-patient relationship which was submitted in May 1950 to the California Medical Association and the Alameda County Medical Association by Ernest Dichter, Ph. D. Among a great many fundamental observations in that report was the recognition of the great importance of the high cost of medical care to an understanding of the doctor-patient relationship. Dr. Dichter reported that most of the doctors he interviewed admitted readily that, in general, costs were high, but that the general attitude he detected could best be characterized as one of defensiveness. He also noted that the real determinant for a doctor's fee was the doctor's own self-evaluation, which was usually quite high, and that this evaluation of his own work was generally the most real and deep criterion used by the doctor in determining fees.

Dr. Dichter was told that competition dictated the fee to a considerable extent, and that standard fees were determined by customary rates in the area, but he noted that the doctor's own self-evaluation determined whether he felt he must be bound by local customs or might set his own standards. Dr. Dichter concluded that while the problem of costs and fees was a very major one, an important step to its resolution would be accomplished if each physician would charge equal prices to everyone he treated.

The study by Dr. Dichter was extended by a summary and projection of his report, and by some action recommendations, by Mr. Rollen Waterson, who was then the executive secretary of the Alameda-Contra Costa Medical Association, and Mr. William Tobitt, who was then the executive secretary of the Orange County Medical Association. Among many valuable suggestions of this Waterson-Tobitt projection, there occurred the recommendations "that each physician set his own valuation of his services and make available to patients his schedule of fees," and "that the medical association officially condemn the practice of charging those better able to pay more than the value of the services set by the physician and contained in his own schedule of fees."

Significant further development of these themes occurred in the report of a special California Phy-

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sicians' Service Study Committee (chairman: Dr. Wilbur Bailey of Los Angeles) which reported to the California Medical Association House of Delegates in 1952. Among the recommendations of this study committee report were:

> "That each individual physician be urged to accept the principle of individual conformity of fees, and to formulate an individual fee list to which, in the absence of agreement with his patient to do otherwise, he will adhere. . . .
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> "That each component county medical society of the California Medical Association, or its branches, be urged to formulate and regularly revise a fee list whose basis shall be the average fee charged the average patient by the average physician in its county. . . .
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> "That the California Medical Association formulate a state fee list, which shall be a composite of county lists, and which may be adopted by any county as its list in lieu of a locally determined one. The purpose of county and state fee lists shall be to serve as guides to insurors in formulating realistic indemnity schedules."

On this basis, the study committee proposed, and strongly urged, a type of indemnity plan under California Physicians' Service, for which it proposed the term "average fee plan." The committee noted that while this proposal was based on a kind of fee schedule, the term *fee schedule* savored too strongly of the element of compulsory acceptance; the committee suggested that the purpose of the "average fee plan" was to avoid such compulsive conformity, and proposed the term *fee-lists* for the kinds of schedules required.

The term *average* applied to fees, physicians and patients stimulated significant resentment, and to many people the term *fee-list* was not clear. As a result, unfortunately, the study committee report was neither well understood nor well accepted. It was not highly regarded by the then current Board of Trustees of California Physicians' Service, who were deeply distracted by other problems at the time, and the suggestions of the study committee report were not immediately implemented. However, the report was referred to the newly formed Medical Services Commission of the California Medical Association. This committee, under the leadership of Dr. Leslie Magoon, continued a study and review, and prepared a restatement of the proposed "average fee plan." This restatement, entitled *Problems of Medical Care Insurance and the Usual Fee Indemnity Plan, a Restatement,* was submitted to the Council of California Medical Association in May of 1954.

The Medical Services Commission report is an excellent study of insurance fundamentals. Unfortunately, it was never widely publicized to California physicians, nor was it well accepted at the time by the California Medical Association Council or House of Delegates. The report did note that an insured person will have certain "adequate" protection against financial shock only if his insuring agency's indemnity schedule approaches or becomes identical with his physician's fees. However, the individual physician must first set his own fees, and physicians in any community must first establish the level, and relative values, of community fees before any insuring agency can find a way to make its indemnities approach these established fees. The report then explored whether there was any possible compromise to a fixed fee schedule which would allow physicians to control their own individual fees and which could recognize that there are variations in ability among physicians, and variations in difficulty of care among patients, which should be reflected in the fees to be paid. Following the lead of the earlier California Physicians' Service study committee, this Medical Services Commission restatement concluded that a very satisfactory compromise was indeed possible. The restatement substituted the term *usual fee* for *average fee* and re-presented a "usual fee indemnity plan" which it summarized as follows:

> USUAL FEE INDEMNITY PLAN
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> If a physician charged the same fee for the same service to each of his patients it would be possible to write an indemnity policy, based on these fees, which would give real certainty and adequacy of reimbursement to the patients receiving his services.
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> Similarly, if each physician charged the same fee for the same service to each of his patients, and if most of the physicians in a community had very similar fees, it should be possible to write an indemnity type insurance contract which would give certain, adequate reimbursement to the patients of this majority group of physicians.
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> If, on the other hand, a patient sought care from a physician whose individual fee schedule was higher than that of most of the physicians in his community (by reason of unusual skill, experience or prestige), so long as the higher schedule was known to the patient, he would still have certainty of reimbursement to the extent that he would know exactly how much greater his expenses would be than the reimbursement schedule, and he would then knowingly and willingly be accepting less than complete reimbursement from his insurance.
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> In the same way, any physician anticipating unusual difficulties in the care of a particular case should have the privilege of charging more than his usual fee by reaching an understanding with the patient concerned; after explanation of the unusual problem, before service was given. If there were to be any deviation from the usual fee, the patient should know it in advance.
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> Briefly, the usual fee indemnity plan proposes that the insuring agency repay to the insured person most

of what he has spent for medical care. If his physician charges him the usual fee charged by most doctors in his community, the amount repaid will be nearly all he has spent.

This is just what most owners of medical care insurance thought they were going to receive when they bought their insurance.

While concomitant studies were going on elsewhere, it appears that these quoted California studies did introduce, and did most clearly define, the term *usual fee* and the importance of the concept in establishing certainty of insurance coverage while safeguarding freedom of action for both patient and physician.

During the next few years, a considerable amount of continuing exploration of the concept of payment of the "usual" fee of physicians went on, both in California and elsewhere (notably in Wisconsin and Indiana).

The Wisconsin Physicians Service had become interested in the possibility of a full-payment program, with no fee schedules and no income limits. In 1954, Wisconsin Blue Shield offered a major illness program of payment, with deductibles and coinsurance, based on the customary, usual and reasonable charges of the physicians. A "no fee schedule" program was introduced in Racine and Eau Claire counties in 1955, and, as a result of the successful experiment in these areas, was made available throughout Wisconsin in 1957. Payment in full was provided on a physician's charges which were deemed to be customary, usual and reasonable if they did not exceed the general level of charges by other physicians who rendered such services under similar or comparable circumstances within the medical community in which the charge was incurred.

In Indiana a military dependent's medicare program was successfully operated as early as 1956, without any formal fee schedule and with the physician charging his usual fees.

A very significant development for California occurred when the studies of the Riverside County Medical Association, beginning in 1957, convinced the group of physicians embraced in that association that labor wanted certainty of coverage with no income ceiling, and that doctors wanted no fixed fee schedule. In 1959, the Riverside association requested that California Physicians' Service offer a "no income clause" program. Such a program was actually written for one insured group (Food Machinery Corporation) on a pilot basis, and was based on the payment of "usual, customary, and reasonable" fees; and these terms were carefully spelled out and defined in the contract itself. With careful administrative review of claims operations, done by Riverside physicians headed at that time by Dr. Herman Stone, the program was very well received; it soon spread to many other groups in the Riverside area and then to many other areas in California, which experimented with the concept, and with its control by careful continuing administrative review by physicians.

In 1962 a special interim study committee of the California Medical Association House of Delegates, which was then studying the problems of physicians' fees for welfare medical care programs, took another look at the concept of usual, customary or reasonable fees. This committee learned that, from a dictionary or legal standpoint, the terms did not have a separate and distinct meaning. The committee recognized that the definitions proposed by the Riverside County Medical Association, (which had been later adopted almost verbatim by the California Medical Association) did make very important distinctions between the terms usual, customary, and reasonable, but that these distinctions were valid only because they were defined in the contract, rather than because of their intrinsic meaning or general usage.

(As a matter of interest, this interim study committee did itself make a significant error when it recommended that the California Medical Association advise the California State Leigslature that "the payment of physicians for contractual services rendered be based upon what is the usual, customary or reasonable fee for that individual physician." It is obvious, in retrospect, that there is no "customary" fee for an *individual* physician in the light of the original Riverside definitions.)

The terms *usual, customary* and *reasonable* gradually spread across the United States, stimulated by concurrent thought and independent experiment in several areas more or less at the same time. A number of Blue Shield Plans, with a similar objective, introduced the concept of paying physicians' fees on the basis of the "prevailing fee" in the area. The term *prevailing* seemed very similar to the concept of the earlier term *customary*. However, *prevailing* was defined in different ways by different groups; it was found to have no consistent meaning in common usage or in law, and its use appeared to erode the clarity of the terms *usual, customary* and *reasonable.*

Even where the original terms were retained, their meaning became blurred, and for many

parts of the United States the phrase "usual and customary" has been widely used in such a way as to make the terms almost synonymous, or interchangeable.

The confusion in terms, and the need for commonly understood definitions, became even more apparent with the development of the United States Federal Medicare Law in 1965. This law authorized payment of physicians' fees on the basis of a "reasonable" charge in whose determination "there shall be taken into consideration the customary charges for similar services generally made by the physician . . . as well as the prevailing charges in the locality for similar services." On careful study of the law, its original intent, and its subsequent administrative interpretation, it became clear that there was really a close similarity in concept, if not in words, between this law and the usual, customary, and reasonable idea and that an equivalence of meaning could be established. Thus, Mr. Howard Hassard, legal counsel for the California Medical Association, as well as for the California Blue Shield and the National Association of Blue Shield Plans, pointed out in March 1966 that *reasonable* in these statutes is defined precisely as in the common law rule, but that the statute uses the term *customary* where the common law uses the word *usual,* and uses the word *prevailing* where the common law uses the word *customary,* but the criteria are identical.

It remained for Mr. Arthur Hess, the administrator of the Federal Medicare Law in its early days, to introduce another clarifying concept, namely that the term *customary* (called *prevailing* under the Medicare law), should refer to those charges which fall within the range of charges *most frequently* and *most widely used* in the locality for particular medical procedures or services. The same administrator suggested that the range of prevailing charges in a locality might well turn out to be different for physicians engaged in a specialty practice than for those who engaged primarily in general practice, and that this might lead to the development of more than one range of such customary or prevailing charges for application by the insurance carrier.

Many very interesting distortions have occurred, and will probably continue to occur in the future, in the use of these terms. For example, an interim study of the California State Legislature proposed that physicians' fees in the California medicaid program (Medi-Cal) be paid on the basis of usual, customary or reasonable, *whichever is least.* The same program, while purporting to follow the "reasonable, customary, and prevailing" concept of the Federal Medicare Law, has grossly distorted this concept by back-dating the level of payment to an experience nearly two years old, with no opportunity for up-dating in response to the general inflationary trend of the entire economy; it has even limited the top of the range of payable fees to the sixtieth percentile of this outdated base. Similar distortions are occurring in many other parts of the United States. (It is to be hoped that the California experience may be corrected at an early date by the adoption, as a basis of payment, of the California Blue Shield physician profile system to determine what is the customary range of usual fees in California communities.)

The value of this usual, customary and reasonable concept is better recognized with each passing day. The inherent opportunity to provide certainty or near certainty of coverage (as in "paid-in-full" contracts), with no income ceiling for the insured, and with no fixed fee schedule for the physician, is producing wide acceptance of the terms and the ideas behind the terms. Their survival and their usefulness, however, depend in very large measure on accurate and commonly understood definition of them, and a uniformity of meaning wherever the terms are used.

At the clinical convention of the American Medical Association in Miami Beach, in December 1968 it was formally recognized, by the House of Delegates, that there is a growing tendency to incorporate the terms *usual, customary* and *reasonable* into national contracts for insurance. It was realized that this required a clear definition of the terms used in any given contract. For this reason, the American Medical Association House of Delegates officially adopted, as guideline definitions for this purpose, a series of definitions very similar to those which had been initiated by the California Physicians' Service in Riverside County in 1958 and had been in use by the California Medical Association since that date. These American Medical Association definitions read as follows:

". . . That the AMA adopt the following definitions and distribute them to all state medical associations for their individual consideration and guidance:

" 'Usual' is defined as the 'usual' fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual

fee); 'Customary' is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socio-economic area; 'Reasonable' is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question."

The House also resolved that "whenever these terms are used in contracts or laws, they be specifically defined in those documents."

It is increasingly clear that the continuing viability of the *usual, customary* or *reasonable* idea must rest on close adherence by each individual physician to a uniform system of charging the same fee for the same service to each person in his practice. It must also rest on accurate identification by insuring agencies of the actual range of such usual charges in each community, as well as in each specialty, and on the conscientious recognition of factors in the care of any particular patient which may make charges reasonable in particular circumstances which would not be usual for the individual physician or customary for the community.

The actual determination of the range of usual fees which is customary for any particular community, and the circumstances which can make a non-conforming charge reasonable, will require the utmost in understanding, forebearance, and cooperation of peer review committees of physicians in each community. Wide interest, support and participation, of as many physicians as possible in each community, in such peer review activities, is a very vital public service function of the medical profession.

It is clear that the appropriate and optimal use of the *usual, customary* or *reasonable* criteria for payment of physicians' fees offers a very fundamental contribution to resolution of problems of cost, utilization and availability of essential medical care services to the American people, and to strengthening of existing insurance mechanisms throughout the United States.

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DIAGNOSIS OF LIVER INJURIES

"Much has been written about the diagnosis of liver injuries, and there are many available diagnostic criteria. Penetrating wounds by their very presence demand exploration. The once traditional probing is purposeless at best and deceiving at worst. Nor can we confess to any enthusiasm for the injection of radiopaque materials or other time-consuming attempts to demonstrate peritoneal penetration. The latter can easily be determined by a small incision at no risk, if the peritoneum is intact. The incision can be enlarged for further exploration if peritoneal penetration has occurred. Negative explorations are associated with minimal morbidity and mortality. The same can assuredly not be said for failure to explore patients who have sustained serious intraperitoneal damage."

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